Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DONALD M. MCPAUL, MD
3100 TIMMONS LANE STE 250
HOUSTON, TX 77027

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-12-0832-01

MFDR Date Received
NOVEMBER 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay full amount due for services rendered even after a request for reconsideration was submitted along with proof of first submission which was faxed June 22, 2011.

Amount in Dispute: $911.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Office performed an in-depth review of date of services 6/8/2011 and determined that the original submissions of this date of service was returned to the provider as the Tax ID in box 25 was not valid in our system. The provider included a W9 and Ap-152 form with the bill submission on 10/14/2011. An immediate re-audit of this date of service has been requested to waive timely filing and allow reimbursement pursuant to the Division's rules and payment policies to include interest if applicable."

Response Submitted by: State Office of Risk Management, P.O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2011	99202, 95861, 95900, 95904, A4556	$911.02	$110.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of Workers' Compensation Professional Services provided on or after March 1, 2008.

4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 27, 2011

   29- The time limit for filing has expired.
8. The requestor submitted an updated Table of Disputed services on December 13, 2011 which shows that the respondent made payment in the amount of $768.98 for the disputed services. The total amount in dispute is now $142.04.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor submit documentation to support that the disputed bills were submitted timely in accordance with Texas Labor Code § 408.027 and 28 Texas Administrative Code § 102.4?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the requestor's submitted documentation finds a copy of a fax transmission verification report which sufficiently supports that a bill was submitted to the respondent on June 22, 2011.
3. The requestor submitted a medical bill to the respondent within 95 days from the date the services were rendered in accordance with Texas Labor Code §408.027. Therefore, reimbursement is recommended in accordance with 28 Texas Administrative Code §134.203 as follows:
   - CPT code 99202: WC CF 54.54/33.9764 Medicare CF x 68.75 Participating amount = $110.36.
   - CPT code 95861: WC CF 54.54/33.9764 Medicare CF x 126.64 Participating amount = $203.29. The respondent made payment in the amount of $211.30. No additional reimbursement is recommended.
   - CPT code 95900: WC CF 54.54/33.9764 Medicare CF x 57.52 Participating amount x 4 units = $369.33. The respondent made a payment in the amount of $387.12. No additional reimbursement is recommended.
   - CPT code 95904: WC CF 54.54/33.9764 Medicare CF x 50.64 Participating amount x 2 units =162.58. The respondent made a payment in the amount of $170.56. No additional reimbursement is recommended.
   - CPT code A4556: Per the National Correct Coding Initiative (NCCI) edits, Medicare considers this a bundled/excluded code. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $110.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $110.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		01/18/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.